



Member Information Sheet

Name: _____

Affiliation: _____

Address: _____

Phone#: _____ Fax#: _____

E-mail Address: _____

Please check all that apply:

- ☐ Person with diabetes
☐ Family member of someone with diabetes
☐ Health Care Professional, List Credentials _____
☐ Other – please list _____

DPAC Workgroups and Committees

Please check below the committee or workgroup you would like to join.

- | | |
|---|---|
| <input type="checkbox"/> <u>Communication/Public Awareness Workgroup</u> (Purpose: increase public awareness.) | <input type="checkbox"/> <u>Data/Research Workgroup</u> (Purpose: identify and enhance available data systems; develop a research advisory consortium; address issues of cost and quality of care.) |
| <input type="checkbox"/> <u>Policy/Advocacy Workgroup</u> (Purpose: advocate for people with diabetes; address health disparities and access to care issues.) | <input type="checkbox"/> <u>Governance Committee</u> (Purpose: provide oversight on matters related to the structure and governance of DPAC.) |
| <input type="checkbox"/> <u>Program/Education Training Workgroup</u> (Purpose: improve and promote culturally relevant and sensitive diabetes education services and care.) | <input type="checkbox"/> <u>Membership Committee</u> (Purpose: develop the membership that leads DPAC to thrive, fulfill its mission, and to achieve its vision.) |
| <input type="checkbox"/> <u>Prevention Workgroup</u> (Purpose: expand diabetes primary prevention activities.) | |

I, _____, agree to join DPAC, to endorse the DPAC membership expectations, and to promote the mission of DPAC. I also give permission to include my name on written materials or web sites as a supporter of DPAC.

Signature

Title

Date

Please return to Megan Goff

Fax to: Megan Goff at 517-335-9461

Mail to: Michigan Department of Community Health, Diabetes Section, C/O Megan Goff, 109 Michigan Ave, 7th Floor, Lansing, MI 48913